Supreme Court, U.S
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No. 93-105

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

BLUE CROSS AND BLUE SHIELD OF MARYLAND, INC.,
Petitioner

v.

UNITED STATES OF AMERICA,
Respondent

Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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PETITION FOR WRIT OF CERTIORARI

M. ALBERT FIGINSKI
(Counsel of Record)
WEINBERG AND GREEN
100 S. Charles Street
15th Floor
Baltimore, MD 21201
(410) 332-8634

PHILIP V. TAMBURELLO
10455 Mill Run Circle
Owings Mills, MD 21117
(410) 998-5478
Attorneys for Petitioner

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

QUESTION PRESENTED FOR REVIEW

WHETHER THE COURTS BELOW HAVE ALLOWED 38 U.S.C. § 1729 TO DISPLACE 42 U.S.C. § 1395ss AND RELATED MEDICARE PROVISIONS WITHOUT PROPERLY CONSIDERING HOW SUCH CONFLICTING PROVISIONS COULD BE HARMONIZED SO THAT EACH IS EFFECTIVE IN ITS OWN SPHERE?

PARTIES

The parties to the proceeding in the United States District Court for the District of Maryland (hereinafter mostly referred to as the "District Court") were as follows:

United States of America

Blue Cross and Blue Shield of Maryland, Inc.,

In the Circuit Court of Appeals for the Fourth Circuit (hereinafter mostly referred to as the "Fourth Circuit"), the Blue Cross and Blue Shield Association filed an amicus brief. The address for the Association is 676 N. St. Clair, Chicago, Illinois 60611.

Blue Cross and Blue Shield of Maryland, Inc., has the following subsidiaries: Healthline, Inc.; Paradigm Pharmacy Management, Inc.; Community Health Service, Inc.; * Sterling Health Services, Inc.; CFS Health Group, Inc.; ** and Columbia Medical Plan, Inc.***

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* Community Healthline Services, Inc. has the following subsidiaries: Willse and Associates, Inc. and Lifecard International, Inc.

** CFS Health Group, Inc. has the following subsidiaries: Freestate Health Plan, Inc.; Healthcare Corp. of the Mid-Atlantic; and Healthcare Corp. of the Potomac.

*** Columbia Medical Plan, Inc. has the following subsidiary: Patuxent Medical Group, Inc.

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UNITED STATES OF AMERICA,
Respondent

Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

---

PETITION FOR WRIT OF CERTIORARI

The petitioner, Blue Cross and Blue Shield of Maryland, Inc., by its attorneys M. Albert Figinski and Philip V. Tamburello, for its Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit states the following:

DECISIONS BELOW

The decision of the District Court is captioned as *United States of America v. Blue Cross and Blue Shield of Maryland* and is reported at 790 F. Supp. 106 (1992).

The decision of the Fourth Circuit is captioned as *United States of America v. Blue Cross and Blue Shield of Maryland, Inc.* and is reported at 989 F.2d 718 (1993).

JURISDICTIONAL BASIS

(i) On March 22, 1993, the Fourth Circuit filed its opinion affirming the judgment of the District Court entered on May 14, 1992.

(ii) The Fourth Circuit denied Blue Cross's Petition for Rehearing and suggestion for rehearing in banc on April 16, 1993.

(iii) This is not a cross petition.

(iv) This Court has jurisdiction pursuant to 28 U.S.C. § 1254. This petition is filed within the time period established by this Court's Rule 13.4.

STATUTES

The statutes relevant to this case are: 38 U.S.C. § 1729; 42 U.S.C. § 1395ss; 10 U.S.C. § 1095.

Because the above statutes are lengthy, their pertinent text is set forth in the Appendix to this Petition.

STATEMENT OF THE CASE

The Fourth Circuit decided the case on appeal from a grant of summary judgment by the District Court in favor of the United States. The case was appropriate for summary disposition because the facts were undisputed. The Fourth Circuit, however, erroneously interpreted the statutes involved in this proceeding. The intermediate appellate court, nonetheless, set forth a concise statement of the case, writing, 989 F.2d at 719-720:

> The facts of this case are straightforward and undisputed. Eleven veterans, who held Medicare supplemental ("medigap") policies issued in Maryland by Blue Cross & Blue Shield of Maryland, Inc. ("BCBS"), received medical care and treatment at the Department of Veterans Affairs Medical Center in Martinsburg, West Virginia for non-service-connected disabilities. The veterans all were over the age of sixty-five and were eligible to receive Medi-

care benefits. See 42 U.S.C. § 1395c. Because the veterans were treated at a Veterans' Administration ("VA") hospital however, they were not required to pay for the services they received and did not claim Medicare benefits. When the United States filed claims with BCBS for reimbursement on behalf of the veteran patients, BCBS responded that its medigap policies covered only those medical expenses incurred in a manner that would trigger Medicare coverage as well.

The United States brought this action in the district court for the District of Maryland to collect benefits under the BCBS medigap policies asserting that a non-discrimination section of the Veterans' Benefits Act, 38 U.S.C. § 1729, prohibited BCBS's non-payment.

REASON FOR GRANTING THE WRIT

THE COURTS BELOW HAVE ALLOWED 38 U.S.C. § 1729 TO DISPLACE 42 U.S.C. § 1395ss AND RELATED MEDICARE PROVISIONS WITHOUT PROPERLY CONSIDERING HOW SUCH CONFLICTING PROVISIONS SHOULD BE HARMONIZED SO THAT EACH IS EFFECTIVE IN ITS OWN SPHERE.

The courts below failed to even consider the appropriate legislative interpretive tool [1] required to be applied upon the collision of two federal statutes enacted at different times and without the later statute referring to the earlier statute. The colliding provisions are, on the one hand, in the case at bar, 38 U.S.C. 1729 (hereinafter cited as "§ 1729") and, on the other hand, 42 U.S.C. 1395ss (hereinafter cited as "§ 1395ss") and the federally approved NAIC Guidelines therein incorporated.

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[1] The proper judicial course is articulated in *Posadas v. National City Bank*, 296 U.S. 497, 503, 56 S.Ct. 349, 352, 80 L.Ed. 351, 355 (1936); *Radzanawer v. Touche Ross and Co.*, 426 U.S. 148, 96 S.Ct. 1989, 48 L.Ed.2d 540, (19—); *Morton v. Mancari*, 417 U.S. 535, 549-550, 41 L.Ed.2d 290, 300, 94 S.Ct. 2474, —— (1974); CF., *U.S. v. Borden Co.*, 308 U.S. 188, 198-199, 84 L.Ed. 181, 190-191, —— S.Ct. —— (1939).

Section 1729, enacted originally in 1981 and amended by the Comprehensive Omnibus Budget Reconciliation Act of 1986 (hereinafter referred to as "COBRA") allows the United States to collect under a "health plan contract" the reasonable cost of health care services provided under the Veterans' Benefits Act to veterans for a non-service connected disability. Section 1729 makes no direct reference to the Medicare exclusions for services provided in federal hospitals [2] although it excludes Medicare from the term "health plan contract."

As defined in § 1729, a "health plan contract" did not specifically encompass within its scope a medigap policy. Moreover, COBRA did not specifically repeal § 1395ss which establishes and defines a medigap policy.

In 1982, by the so-called Baucus Amendment (42 U.S.C. 1395ss), Congress created a statutory definition of a medigap policy, §§ 1395ss(g)(1), a certifying mechanism for such policy, §§ 1395ss(b), and otherwise regulated and provided for such contracts.

In brief, a medigap policy is an insurance plan offered to those who are *entitled* to Medicare benefits; only provides reimbursement for Medicare approved charges not reimbursable because of the applicability of deductible, coinsurance amounts or other Medicare imposed limitations. FR Vol. 55 No. 225, p. 48695. Medigap policies are designed to fill specific gaps in the Medicare benefit structure. These contracts typically offer coverage of some or all of Medicare's deductible and coinsurance amount. FR Vol. 55 No. 225, p. 48694.

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[2] Medicare does not pay benefits for services performed in a federal institution, 42 U.S.C. 1395y(a)(3), except in certain limited circumstances irrelevant to these proceedings.

In 1966, Congress etablished the Medicare program which exists in two parts, i.e., "Part A," a hospital insurance benefits program and "Part B," a supplemental medical insurance program covering certain costs of physicians and other providers of health care services. Under both parts, Medicare benefits to any federal provider of services are excluded. (42 U.S.C. 1395y(a)(3))

None of these provisions dealing with medigap policies was repealed by § 1729. In the absence of repeal, the medigap statute would only be modified by § 1729, if § 1729 impliedly repealed them. Repeal by implication is an unfavored device, acceptable, if at all, only where the implied intent to repeal is *clear and manifest* * * *; *Posadas v. National City Bank*, 296 U.S. 497, 503, 56 S. Ct. 349, 352, 80 L.Ed. 351, 355 (1936).

In this case, all of the indications and inferences from Congress are that the pre-existing medigap provisions were *not* to be repealed by implication. Among the indicators are (1) the specific limitation of § 1729 to state law by §§ 1729(f) the so-called "Override Provision"; (2) the particular mechanism used to define the term "health plan contract;" (3) Legislative history that compares the term "health plan contract" in §§ 1729(i) to an employer/employee group contract which is a primary health insurance contract and not a supplemental contract; and the statutory exclusion of employer/employee insurance plans from the definition of medigap policies, § 1395ss(g)(1); (4) action by the 101st Congress to amend relevant provisions in § 1095 (which is similar in purpose to § 1729) to include a medigap policy; and (5) two unsuccessful attempts during the 101st Congress to amend Subsection 1729(i) to include medigap policies within the meaning "health plan contract."

1.

The "Override Provision" provides:

> No law of any state or of any political subdivision of a state, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section . . . § 1729(f)

Clearly, § 1729 on its face does not repudiate any other provision of federal law; it only supersedes state law. See 1981 U.S.C.C.A.N. 1962; 1986 U.S.C.C.A.N. 575. If Congress had wanted to renounce federal laws and to

include a medigap policy within the scope of health plan contracts contemplated under § 1729, it could have added the word "federal" to 38 U.S.C. § 1729(f), e.g. "*No federal law nor any* 'law of any state, etc.' " This simple change would have broadened the Override Provision to nullify conflicting federal laws.

2.

Subsection 1729(i)(1)(B)(i) uses the word "*means*" in defining the term "health plan contract." A definition which declares what a term "means" excludes any meaning that is not stated. 2A. Singer, *Sutherland Statutory Construction*, section 47.07 Fourth ed., *Colautti v. Franklin*, 439 US 379, 392, 99 S.Ct. 675, 684 (1979) footnote 10. Moreover, Congress is presumed to legislate with knowledge of the court's rules of statutory construction. *McNary v. Haitian Refugee Center, Inc.*, 111 S.Ct. 888 (1991).

Since Congress employed the word "means" in defining the term "health plan contract," it limited that term to the language used in the definition. That language does not specify a medigap policy. Moreover, medigap policies are not referenced in the 1986 House Report (99-241) relating to the COBRA amendments to § 1729 nor the section by section analysis to said amendments. Additionally, the General Accounting Office study, *Legislation to Authorize VA Recoveries for Private Health Insurance Would Result in Substantial Savings* (GAO/HRD-85-24, Feb. 26, 1985), upon which Congress relied in estimating potential billings for § 1729 as amended in 1986 (1986 U.S.C.C.A.N. 530) excluded from its income projections any billings related to medigap policies[3] and any administrative costs attributable to collection of billings under medigap policies[4] (hereinafter referred to as "GAO Study").

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[3] GAO/HRD-85-24, Feb. 26, 1985, footnote 7 p. 13 and pages 56 & 57.

[4] *Ibid.*, p. 101 & 102.

3.

House Report 99-241 regarding COBRA amendments to § 1729 states:

> The right of the United States to recover the cost of certain care and services from third parties would be revised by the bill. *It would restate the existing provisions of law without substantive modifications* except for the addition of a new category for which the United States may seek recovery. Both the existing and proposed law apply only to care and services for non-service connected disabilities. The new category is for care provided to a Veteran with no service connected disabilities who is entitled to care or reimbursement for care from a third party *such as an employee health care insurer.* This authority would be in addition to the Administration's existing authority to collect under worker's compensation laws, automobile "no fault" insurance policies and "victims of crime" compensation funds. 1986 U.S.C.C.A.N. 579, 1263. (Emphasis supplied.)

The section by section analysis relating to § 1729(i) defines "health plan contract," in relevant part, as follows:

> [A]n insurance policy or contract, medical or hospital service agreement, membership or subscription contract or similar arrangement, under which health services for individuals are provided or the expenses of health services are paid. . . . [T]he definition is to be construed broadly so as to achieve broad coverage with respect to the types of health plans under which recoveries . . . may be sought. 1986 U.S.C.C.A.N. 576.

Although § 1729(i) and its section by section analysis does not define the term "health plan contract," House Report 99-241 compares a health plan contract with an employee health care insurer. Such a comparison suggests a group health insurance contract which is a primary health insurance contract or one that pays first dollar benefits. Because "health plan contract" is to be

broadly construed, such term would include all types of primary health insurance coverage including various types of individual health insurance contracts. A primary health insurance program, either group (employer/employee) or individual, covers a majority of persons in this country who have health insurance coverage.

The difference or distinction between a primary health insurance contract and a medigap policy, is so fundamental as indicated hereinafter that the failure to enumerate a medigap policy in the definition of health plan contract clearly demonstrates that Congress did not intend to include a supplemental contract within the meaning of a health plan contract.

First, a primary health insurance contract specifically enumerates in written policy format, the benefits that are available, exclusions and conditions relating to the payment of benefits, eligibility requirements, standards relating to medical necessity, the amount or value of the available benefits and other matters. A primary health insurance carrier administers the written provisions of its health insurance contract by making administrative determinations as to the scope of benefits available, exclusions and conditions relating to the payment of benefits, eligibility requirements, medical necessity, and the amounts payable to health care providers. On the other hand, a medigap policy is structured so that the determinative administrative functions are performed by Medicare carriers and intermediaries through a Medicare Benefits Determination [5] and not by the insurance company that issues medigap policies.

Second, a primary insurance contract provides initial first dollar benefits and not benefits that are in addition to or supplemental to first dollar benefits.

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[5] 42 C.F.R. 421.100(a) as to intermediaries and 42 C.F.R. 421.200(a) as to carriers.

Third, premiums for medigap policies are much lower than premiums for primary insurance contracts because the administrative costs relating to a Medicare Benefits Determination for a medigap policy are incurred by Medicare.

In view of the differences between a primary health insurance contract and a medigap policy, and in light of the fact that the term "health plan contract" is compared with an employer/employee group contract, Congress did not intend to include a medigap policy within the meaning of the term "health plan contract."

4.

Interpretation of a companion enactment to § 1729 reflects Congressional ability to encompass medigap policy when it so wished.

Apart from § 1729, COBRA authorized the United States to recover from a third party payor the reasonable costs of certain health care services provided by a military facility to certain members and retired members of the Armed Forces and dependents of active duty military personnel to the same extent that said person would be eligible to receive benefits from a third party payor if such person were to incur such costs on the person's own behalf, 10 U.S.C. § 1095 (hereinafter referred to as "§ 1095"). Subsection 1095(h) defined third party payor as "an entity that provides an insurance, medical service or health plan by contract or agreement." This definition is clearly similar to that set out in the VA Collection Statute, 38 U.S.C. § 1729(i)(1)(A).[6]

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[6] *Water Quality Association Employees' Benefit Corporation v. U.S.*, 795 F.2d 1303, 1307-8 (7th Cir. 1986) suggests that when two statutes, such as § 1095 and § 1729, relate to the same subject, the inclusion of a medigap policy in § 1095 and the omission of a medigap policy in § 1729 evidences a Congressional intent that the term "health plan contract" in § 1729 does not include a medigap policy.

In October, 1989, counsel for the Department of Defense was asked whether § 1095 authorized collection from a medigap policy. Assistant General Counsel to the Department of Defense responded, in pertinent part:

> In our view that the most defensible legal analysis would consider as an essential element of a Medicare Supplemental Insurance Plan the term and condition that its coverage is secondary to that of Medicare. By its nature as a supplemental insurance plan, it defines itself and likely its coverages, limitation, terms and conditions as functions of the underlying Medicare program to which it is a supplement. To attempt to deal with a Medicare Supplemental insurance policy as freestanding and independent of Medicare, we believe *would stray from the intended scope of 1095*. Thus, although not free from doubt, we interpret Section 1095, which does not authorize recovery from Medicare as also not authorizing recovery from Medicare supplemental insurance carriers. (Emphasis supplied.) (App. p. 430.)

In response, the 101st Congress amended Subsection 1095(h) by P.L. 101-510 (104 Stat. 1583, 1584) ("Defense Authorization Act") by adding Subsection 1095 (h)(2) to provide that:

> (2) The term "insurance, medical service or health plan" includes an insurance plan described as Medicare Supplemental insurance.

This legislative action demonstrates the appropriate means to alter the plain words of a statute.

The United States (hereinafter referred to as the "VA") below, by judicial fiat, accomplished what failed in Congress.

5.

The 101st Congress did not act to change § 1729. Senator Alan Cranston, Chairman of the Veteran Affairs

Committee, introduced Senate Bill 2455 (hereinafter referred to as "S. 2455") entitled "Medical Care Cost Recovery Amendments of 1990". Section 5 thereof would have amended Subsection 1729(i)(1)(A) to add additional language:

> For the purposes of this section, such term includes a Medicare supplemental insurance policy as defined in Section 1881(g) of the Social Security Act (42 U.S.C. 1395ss(g)) and with respect to such a policy, Department of Veteran Affairs medical facilities and personnel shall be deemed Medicare participating providers, and medical services covered by such a policy and furnished by the Department of Veteran Affairs shall be deemed Medicare-covered services . . .

S. 2455 did not pass.

Subsequently, Senator Cranston introduced Senate Bill 1271 (hereinafter referred to as "S. 1271") entitled "Medical Care Cost Recovery Amendments of 1991" with section by section analysis. Section 2(b) thereof would have amended Subsection 1729(i)(1)(A) in the same manner as Section 5 of S. 2455, *supra*. Section 3 of S. 1271 provided, in part, as follows:

> Subsection (b) of Section 2 of this Act shall apply with respect to care and services furnished on or after April 7, 1986. (hereinafter referred to as "S. 1271 Retroactive Provision").

The bill died.

Because the 101st Congress amended § 1095 to include a medigap policy but on two occasions failed to so amend § 1729, there would appear to be a disclosed intent that § 1729 does not include a medigap policy. *Madden v. Brotherhood and Union of Transit Employees of Baltimore*, 147 F.2d 439 (4th Cir. 1945).

This conclusion is further supported by the S. 1271 retroactive provision and the equating of VA and VA

services to Medicare participating providers and Medicare-covered services, respectively. There would be no need for the S. 1271 retroactive provision if the term health plan contract under § 1729(i)(1)(A) included a medigap policy. Similarly, there would be no need to equate the VA and VA services with Medicare participating providers and Medicare covered services if the term health plan contract under § 1729(i)(1)(A) included a medigap policy.

To summarize, § 1729, on its face, does not repeal § 1395ss and there are sufficient reasons to conclude that Congress did not intend for § 1729 to include a medigap policy within the meaning of the term "health plan contract" under § 1729(i).

Moreover, §§ 1729 and 1395ss are not in "irreconcilable conflict" in the sense that there is a positive repugnancy between them or that they cannot mutually coexist. Helpful in this regard is *Radzanawer v. Touche Ross & Co.*, 426 U.S. 148, 96 S.Ct. 1989, 48 L.Ed.2d 540. In *Radzanawer,* the Court stated this following:

> . . . . It is not enough to show that the two statutes produce differing results when applied to the same factual situation, for that no more than states the problem. Rather, "when two statutes are capable of co-existence, it is the duty of the courts . . . to regard each as effective . . .
>
> 'Repeal is to be regarded as implied only if necessary to make the [later enacted law] work, and even then only to the minimum extent necessary. This is the guiding principle to reconciliation of the two statutory schemes.' 426 U.S. at 155, 96 S.Ct. at 1983.

It is unnecessary for § 1729 to subsume § 1395ss in order for § 1729 to work. As indicated in the GAO Study,[7] § 1729 was directed to primary health insurance contracts and in that regard should be enormously successful.

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[7] See n.3, p. 6, *supra.*

Because § 1729 can operate without § 1395ss, both statutes are capable of coexistence and the courts below should have regarded each as effective in its own sphere without § 1729 displacing § 1395ss.

CONCLUSION

For the above reasons, the petitioner prays that this court issue a Writ of Certiorari to the United States Circuit Court of Appeals for the Fourth Circuit in order to review that court's analysis regarding conflicting federal statutes in light of this court's principle of statutory construction that repeal by implication of an earlier statute by a later enacted statute is unfavored and should only be utilized in order to make the latter statute work.

Respectfully submitted,

M. ALBERT FIGINSKI
(Counsel of Record)
WEINBERG AND GREEN
100 S. Charles Street
15th Floor
Baltimore, MD 21201
(410) 332-8634

PHILIP V. TAMBURELLO
10455 Mill Run Circle
Owings Mills, MD 21117
(410) 998-5478
Attorneys for Petitioner

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 92-1781

UNITED STATES OF AMERICA,
Plaintiff-Appellee,

v.

BLUE CROSS & BLUE SHIELD OF
MARYLAND, INCORPORATED,
Defendant-Appellant.

BLUE CROSS AND BLUE SHIELD ASSOCIATION,
Amicus Curiae.

Appeal from the United States District Court
for the District of Maryland, at Baltimore.
Joseph H. Young, Senior District Judge.
(CA-90-2653-Y)

Argued: February 1, 1993

Decided: March 22, 1993

Before ERVIN, Chief Judge, and WIDENER and WILKINSON, Circuit Judges.

Affirmed by published opinion. Chief Judge Ervin wrote the opinion, in which Judge Widener and Judge Wilkinson joined.

COUNSEL

ARGUED: Philip Vito Tamburello, Office of Corporate Counsel, BLUE CROSS & BLUE SHIELD OF MARYLAND, INC., Owings Mills, Maryland, for Appellant. Colette Jabes Winston, Civil Division, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellee. ON BRIEF: Lawrence A. Richardson, Jr., Office of Corporate Counsel, BLUE CROSS & BLUE SHIELD OF MARYLAND, INC., Owings Mills, Maryland, for Appellant. Stuart M. Gerson, Assistant Attorney General, Jeffrey Axelrad, Roger D. Einerson, Civil Division, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C.; Richard D. Bennett, United States Attorney, Baltimore, Maryland, for Appellee. Roger G. Wilson, Joel E. Gimpel, BLUE CROSS & BLUE SHIELD ASSOCIATION, Chicago, Illinois; Meryl D. Burgin, Owings Mills, Maryland, for Amicus Curiae.

OPINION

ERVIN, Chief Judge:

This case presents the question whether an insurance company offering gap-filling coverage to Medicare patients may construe its coverage to exclude reimbursement to VA hospitals because the hospitals do not derive benefits first from the Medicare system. We hold that it may not, and affirm the district court.

I

The facts of this case are straightforward and undisputed. Eleven veterans, who held Medicare supplemental ("medigap") policies issued in Maryland [1] by Blue Cross

[1] No organization may engage in an insurance business or merchandize insurance products in Maryland without complying with applicable provisions of Article 48A, Insurance Code, of the Annotated Code of Maryland, including the Medicare Supplemental Act. Md. Ann. Code art. 48A, § 1 (1991).

& Blue Shield of Maryland, Inc. ("BCBS"), received medical care and treatment at the Department of Veterans Affairs Medical Center in Martinsburg, West Virginia for non-service-connected disabilities. The veterans all were over the age of sixty-five and were eligible to receive Social Security retirement benefits, thereby making them eligible to receive Medicare benefits. *See* 42 U.S.C. § 1395c. Because the veterans were treated at a Veterans' Administration ("VA") hospital however, they were not required to pay for the services they received and did not claim Medicare benefits. When the United States filed claims with BCBS for reimbursement on behalf of the veteran patients, BCBS responded that its medigap policies covered only those medical expenses incurred in a manner that would trigger Medicare coverage as well.

The United States brought this action in the district court for the District of Maryland to collect benefits under the BCBS medigap policies, asserting that a non-discrimination section of the Veterans' Benefits Act, 38 U.S.C. § 1729, prohibited BCBS's nonpayment. Because BCBS construed the Medicare system as the vehicle barring the government's recovery of benefits, it contended that its medigap policies do not involve prohibited discrimination. The district court disagreed, granting summary judgment for the United States. BCBS appealed.

II

BCBS's position in this case stems from its construction of the interaction between three distinct pieces of health care legislation—the Medicare system, 42 U.S.C. §§ 1395-1395ccc; the Baucus Amendment, which deals specifically with medigap policies, 42 U.S.C. § 1395ss; and the reimbursement and non-discrimination provision of the Veterans' Benefit Act, 38 U.S.C. § 1729. BCBS contends that Congress endorsed medigap policies as a part of the Medicare system, and that, when Congress excluded Medicare from section 1729's application, it similarly

excluded medigap policies. A proper analysis of the validity of this contention rests necessarily upon a brief overview of the structure of the implicated statutes.

The Medicare system, although notably complex, may be summarized for the purpose of this case as a program triggered by a determination of participant entitlement. A patient's entitlement to benefits rests on the outcome of a two-part analysis. First, is the patient eligible for Medicare payments? The patient must be over the age of sixty-five and eligible for Social Security retirement benefits to claim benefits under Medicare. *See* 42 U.S.C. § 1395c. Second, are the claimed benefits covered by Medicare? The benefits claimed must be both recognized by Medicare as a covered expense and considered a reasonable amount for the service provided. *See* 42 C.F.R. parts 409 & 410.

The Medicare system identifies situations in which claims will not be paid despite the patient's eligibility and the benefits' coverage. Three such situations are relevant to this case: (1) when the health care provider is a federal department or agency, 42 U.S.C. §§ 1395f(c), 1359n(d); (2) when services are provided under circumstances in which the patient is under no obligation to pay, *id.* §§ 1395y(a)(2) & (3); and (3) when the health care provider is not a certified participant in the Medicare program, *id.* § 1395f(a). The first two exclusions operate to prevent VA hospitals from collecting Medicare reimbursements. The third exclusion prevents reimbursement for services provided by uncertified institutions, including both private hospitals which might choose not to certify themselves for Medicare payments and VA or other government-sponsored hospitals which by definition cannot seek Medicare certification.

The Medicare system was not designated to pay all incurred medical expenses; therefore, the system leaves the patient with the responsibility of paying various de-

ductibles and coinsurance amounts.[2] In response to these gaps in coverage, private insurers began offering medigap policies. In 1980 Congress enacted the Baucus Amendment, Pub. L. No. 96-265, § 507, 94 Stat. 441, 476 (codified as amended at 42 U.S.C. § 1395ss), to the Social Security Act, to sanction and officially define medigap policies. The statute describes a medigap policy as

> a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this subchapter [42 U.S.C. §§ 1395-1395ccc, Health Insurance for the Aged and Disabled], which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter; but does not include any such policy or plan of one or more employers or labor organizations . . . .

42 U.S.C. § 1395ss(g)(1).

The Baucus Amendment prevents the issuance of medigap policies in a state unless the state legislature requires the application and enforcement of standards set forth in the National Association of Insurance Commissioners Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act ("NAIC standards"). *Id.* §§ 1395ss(a)(2), (g)(2). Although the NAIC standards suggest that a medigap policy, in delineating coverage, may define the term "hospital" to exclude "any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment

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[2] Medicare does not cover fully certain health care services; the lack of coverage occurs despite the patient's compliance with applicable deductibles. In such cases, the patient must pay a portion of the expenses incurred or a coinsurance amount. *See, e.g.*, 42 U.S.C. § 1395e(a)(3).

of members or ex-members of the armed forces," the Maryland legislature opted not to include that definition in its codification of the NAIC standards. Md. Ann. Code art. 48A, §§ 468B-468GH (Supp. 1992). Therefore, the language permitting exclusion of veterans hospitals from medigap coverage is not available to medigap insurers organized and operating under Maryland law. *See id.* § 1 (1991).

BCBS offers a series of medigap policies in Maryland designed to help pay those medical expenses not paid by Medicare. In some cases the BCBS medigap policies cover items excluded from an area generally covered by Medicare such as required deductibles and copayments, while in other cases the policies cover items excluded entirely from Medicare coverage such as expenses for prescription drugs or expenses incurred in a hospital outside the United States. In all instances, the policies indicate that payments will not be made for the following:

> 1. Expenses for services and items not eligible for coverage under Medicare, except as explicitly specified in this Contract;
>
> * * * * *
>
> 4. Expenses for services which are provided for or received in any Federal hospital or facility, or through any Federal, State or local governmental agency or department . . . .

The creation of new insurance products, such as BCBS's medigap policies, to cover mounting health care costs alerted Congress to the possibility that private insurers might be enjoying a windfall from the government's provision of free health care in certain circumstances. Congress recognized that the government's growing expenditures for legislatively mandated health care such as VA hospitals could be defrayed by drawing on these outside sources for reimbursement.[3] In 1986 Congress

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[3] In 1980 Congress rejected a bill that would have enabled the VA to recover the costs of non-service-connected care provided to

enacted legislation allowing recovery from private insurers and reinforcing its position that insurers or other third-party reimbursers not be allowed to discriminate against VA hospitals. Comprehensive Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, § 19013, 100 Stat. 82, 382-85 (codified as amended at 38 U.S.C. § 1729). The legislative history documenting passage of the private insurance reimbursement provision details the intended scope of available reimbursements as follows:

> [N]o third party payer would be required to reimburse the VA for a health care service that is not covered under the terms and conditions of its contracts, policies or other agreements with veterans. Of course, third party payers would no longer be able to refuse to reimburse based on a general exclusion of care provided by the VA.
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> * * * *

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veterans from veterans' health insurance carriers. Instead of mandating direct reimbursement, Congress authorized VA hospitals to investigate, on a case-by-case basis, veterans' ability to defray necessary medical expenses through outside sources. *See* Veterans' Administration Health-Care Amendments of 1980, § 401, 94 Stat. 1030, 1051 (repealed). This modification was

> designed to allow the Administrator to determine whether certain veterans are able, based on outside income, or adequate private insurance coverage, or both, to receive treatment for non-service-connected disabilities outside the Veterans' Administration.

H.R. Rep. No. 958, 96th Cong., 2d Sess. 16 (1980). By not implementing the legislation as passed, the VA failed to carry out the intent of Congress. H.R. Rep. No. 300, 99th Cong., 2d Sess. 786-87 (1986), *reprinted in* 1986 U.S.C.C.A.N. 756, 1261-62.

In 1981 Congress enacted a system of direct recovery against workers' compensation plans, state automobile "no-fault" provisions, and state "victims of crimes" acts. Veterans' Health Care, Training, and Small Business Loan Act of 1981, Pub. L. No. 97-72, § 106, 95 Stat. 1047, 1050-51 (codified as amended at 38 U.S.C. § 1729). Reimbursement from these various state funds proved successful; therefore, Congress revisited the issue of reimbursement from private insurers in 1986. H.R. Rep. No. 300, 99th Cong., 2d Sess. 786-87 (1986), *reprinted in* 1986 U.S.C.C.A.N. 756, 1261-62.

> The bill would effectively nullify any contract provision agreed to after the date of enactment of this measure which seeks to bar the United States from recovery in connection with care furnished in the circumstances described in the bill.

H.R. Rep. No. 300, 99th Cong., 2d Sess. 789 (1986), *reprinted in* 1986 U.S.C.C.A.N. 756, 1264.

The reimbursement and non-discrimination legislation, now codified at 38 U.S.C. § 1729,[4] provides that

> in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability . . . . the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Secretary [of Veterans Affairs]) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if care or services had not been furnished by a department or agency of the United States.

38 U.S.C. § 1729(a)(1). This section permits the United States to seek reimbursement under a veteran's "health-plan contract," or "insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid," excluding the Medicare and Medicaid programs. *Id.* § 1729(i)(1). In addition, "[n]o law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section." *Id.* § 1729(f).

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[4] The section, previously codified as 38 U.S.C. § 629, was amended and renumbered in 1991. Department of Veterans Affairs Codification Act, Pub. L. No. 102-83, § 5(a), 105 Stat. 378, 406 (1991) (codified as amended at 38 U.S.C. § 1729).

III

Against the backdrop of these statutory schemes, BCBS defends its denial of veterans' coverage under its medigap policies with alternative theories. First, BCBS asserts that the medigap policies fully comply with the non-discrimination provisions of 38 U.S.C. § 1729 because they implicate no state law or private contract term that precludes the extension of coverage to veterans treated in a VA hospital. Instead, BCBS insists that the United States itself creates the impediment to coverage by prohibiting Medicare reimbursements to VA hospitals. This prohibition, which allegedly acts to prevent the triggering of medigap policy coverage, stems from federal legislation, not a state statute or contract term. BCBS therefore claims that the implications of this provision are discrimination not prohibited by section 1729.

Second BCBS asserts that the section 1729 reimbursement and non-discrimination provisions do not apply to medigap policies. BCBS supports this contention by arguing that the policies are part of the Medicare system and 38 U.S.C. § 1729 excludes the Medicare system from the sources available for governmental reimbursement. *See* 38 U.S.C. § 1729(i)(1)(B)(i). Namely, BCBS suggests that a medigap policy is not a health-plan contract. We find both of BCBS's arguments without merit.

A

BCBS submits that there is a federal statutory requirement that medigap policies operate necessarily and exclusively in tandem with Medicare payments. BCBS bases its argument on the statutory definition of medigap policies. BCBS focuses on the language in the definition limiting the policies "to individuals who are entitled to have payment made under this subchapter" and limiting the reimbursements to those "for which payment may be made under this subchapter but which are not reimbursable by reason of . . . deductibles, coinsurance amounts,

or other limitations." 42 U.S.C. § 1395ss(g)(1). BCBS suggests that, because VA hospitals are not permitted to seek reimbursement from Medicare, *id.* §§ 1395f(c), 1395n(d), 1395y(a)(2) & (3), VA hospital patients are not entitled "to have payment under this subchapter," *id.* § 1395ss(g)(1), and therefore are not entitled to recovery under a medigap policy.

BCBS's interpretation of the definition of a medigap policy confuses a person's entitlement to Medicare benefits with her actual ability to collect those benefits. As discussed previously, a person may be over sixty-five, eligible for Social Security, and claiming a covered benefit, and thus entitled to Medicare reimbursement, yet still not receive reimbursement because she has not met a deductible, a coinsurance payment, or other limitation. Therefore, the patient may be entitled to Medicare benefits, but not permitted to collect those benefits. This situation is the chief impetus for purchasing a medigap policy.

The statutory exclusion of Medicare payments to VA hospitals provides a limitation to Medicare recovery but not to eligibility for the underlying benefits. Under the definition of a medigap policy, a veteran over sixty-five who collects Social Security and receives services or treatments covered under Medicare would be entitled to receive Medicare benefits but for his treatment in a VA hospital. The veteran's situation is not unlike two other circumstances where a medigap policy *will* pay despite the failure of Medicare to make reimbursement. Review of these situations when coverage occurs despite the unavailability of Medicare benefits demonstrates that BCBS has failed to establish that "[p]ayment under a Medicare Supplemental Contract is only triggered if Medicare provides payment or reimbursement for the incurred services . . . ." Appellant's Brief at 16.

First, Medicare will not pay until other potential payers under a group health plan or workers' compensation program first make payments. 42 U.S.C. § 1395y(b)(2).

If a workers' compensation claim covers all expenses possibly recoverable as Medicare benefits but excludes the deductibles and coinsurance amounts excluded by Medicare, then BCBS will be faced with a claim under its medigap policy for reimbursement for those unrecoverable amounts. BCBS will be asked to reimburse those amounts it would have reimbursed had Medicare acted as the primary payer, not workers' compensation. No terms of the BCBS medigap policies bar payment under this circumstance.

Second, Medicare declines payment for inpatient hospital services furnished to an individual in a hospital located outside the United States unless the hospital is "closer to, or substantially more accessible from, the residence of such individual than the nearest hospital within the United States." 42 U.S.C. § 1395f(f)(1). BCBS's medigap policies provide that

> [t]he Plan will pay; for Medicare Approved Charges for necessary hospital and medical services furnished to you in a hospital or Skilled Nursing Facility outside of the United States. You must be covered under Medicare and payments under Medicare Part A would be made if these same services were furnished to you in the United States.

In essence, BCBS provides coverage in this instance when, but for the location of the treatment, the patient would have received Medicare benefits as well.

Although BCBS's interpretation that federal legislation mandates concurrent Medicare and medigap payments is misguided, BCBS is free to limit contractually its policies' coverage in such a manner so long as the terms do not discriminate in a way prohibited by 38 U.S.C. § 1729. Policy limitations may not create contractual terms or incorporate state statutes that exclude VA hospitals from coverage. BCBS suggests that its medigap policies are not discriminatory because the policies treat VA hospitals

just as they would treat private hospitals that offered their services for free and because the NAIC standards suggested for medigap policies sanction the exclusion of VA hospitals.

Although no circuit court has yet addressed contractual discrimination, this circuit, as well as the Third and Sixth Circuits, have addressed state statutory discrimination. *See United States v. Ohio*, 957 F.2d 231, 233 (6th Cir. 1992); *United States v. Maryland*, 914 F.2d 551, 554 (4th Cir. 1990); *United States v. New Jersey*, 831 F.2d 458, 462-63 (3d Cir. 1987). These three cases reviewed the application of a state act to compensate victims of crime. In each of the states, the compensation act prohibited recovery for care furnished by a VA hospital or without charge.

In *Maryland*, we determined that the operation of the Maryland law discriminated against VA hospitals in violation of 38 U.S.C. § 1729, holding that:

> While it is true that on its face the Criminal Injuries Compensation Act does not discriminate against the federal government, in practice the Board's construction of the Act would prevent recovery by VA hospitals in virtually all cases. . . .
>
> Congress' use of the word "operate" [in 38 U.S.C. § 1729(f)] demonstrates its intent to prevent not only discrimination against the federal government which appears on the face of a state statute, but also discrimination which takes place in practice. . . . Because the Maryland Criminal Injuries Compensation Act's serious financial hardship requirement as applied here will operate in the vast majority of cases to prevent the federal government from recovering its costs in treating crime victims where a private hospital would be able to do so, the Act is in conflict with § [1729] and therefore is without force.

Id. at 552, 554.

More recently, the Sixth Circuit addressed the contention that discrimination does not occur if a private hospital would be treated similarly. Rejecting this comparison and nullifying the discriminatory statute, that court noted

> [t]he state says that the VA may not recover under this language because the state would not reimburse a crime victim/veteran who had been treated in a private hospital or other health care provider which did not charge for its services. . . . The economic reality is that private hospitals do not provide free medical treatment. Thus, the VA is, for all practical purposes, denied recovery under the state statute, while private hospitals are not.

Ohio, 957 F.2d at 233; *see also New Jersey,* 831 F.2d at 463 ("By requiring a veteran's claim to be viewed as if the veteran had sought non-federal care, Congress mandated that the cost of the VA's treatment be viewed as the cost of a non-federal hospital, for which the veteran would have received a bill.").

In keeping with these precedents, BCBS must determine eligibility for medigap coverage as though the veterans had received care from a private billing hospital. The VA has replaced Medicare as the primary payer for services rendered to veterans, and BCBS must make a determination regarding coverage for those expenses Medicare would not have reimbursed. This interpretation of section 1729 and the medigap policies does not mandate coverage; it merely prohibits an exclusion from recovery based on a *per se* rejection of a class of potential recipients (*i.e.,* veterans), but still permits BCBS to exercise discretion in determining eligibility on a case-by-case basis. If a veteran's expenses were unreasonable or otherwise unsuitable as a Medicare benefit, BCBS can decline to reimburse that veteran, but BCBS cannot decline coverage to veterans as a class.

BCBS's reliance on the NAIC standards is similarly misguided. The NAIC standards do suggest that a state, when implementing its regulations to govern medigap policies, may limit covered health care providers in a manner to exclude VA hospitals. Yet this section of the NAIC standards does not control BCBS's policies for several reasons. First, Maryland did not enact this optional measure in the NAIC standards when promulgating its medigap guidelines, Md. Ann. Code art. 48A, §§ 468B-468GH (Supp. 1992); therefore, the exclusion is not available to BCBS policies issued under the authority of Maryland law. Second, the NAIC standards, which are incorporated into the statutory definition of medigap policies by reference, 42 U.S.C. § 1395ss(a)(2), conflict with 38 U.S.C. § 1729's non-discrimination provision. The discretion granted in the NAIC standards to exclude VA hospitals from coverage under medigap policies directly contravenes the non-discrimination mandate of section 1729. Whether the NAIC standards have the force of law or not, any reference to them in establishing medigap policies must comply with section 1729. Therefore, because the exclusive definition in the NAIC standards is permissive, it must give way to section 1729, which is obligatory. BCBS cannot successfully contend that the NAIC standards require it to disregard the expressed intent of Congress that issuers of insurance not discriminate against VA hospitals.

BCBS's suggested interpretation of the medigap policies operates to discriminate against VA hospitals, and that discrimination is rooted in BCBS's contract, not state or federal law. As evidence of this discriminatory intent, the policy states that payments will not be made for "[e]xpenses for services which are provided for or received in any Federal hospital or facility." We reject any interpretation of BCBS's contract or federal law suggested by BCBS that operates to deny reimbursement to VA hospitals.

B

Alternatively, BCBS relies on tools of statutory construction and legislative history to suggest that a medigap policy is not a health-plan contract and thus not encompassed within the gamut of the nondiscrimination statute. BCBS makes a series of arguments to support this theory, all of which are meritless.

BCBS claims that section 1729's failure to prevent federal legislation's discrimination against VA hospitals supports its interpretation that section 1729 does not apply to medigap policies. The exclusion of Medicare benefits to VA hospitals in section 1729, BCBS suggests, dictates the exclusion of medigap reimbursements to VA hospitals. BCBS focuses on the limitation of section 1729's ban on discrimination to state law, ignoring the fact that the ban extends to private contractual terms as well. As discussed previously, the discrimination attempted by BCBS is contractual, not legislative, so Congress's decision to prohibit state but not federal statutes' discrimination against VA hospitals has no bearing on the inclusion of medigap policies in the definition of health-plan contracts.

BCBS characterizes the term "means" used to define health-plan contract in 38 U.S.C. § 1729(i)(1) as having a narrowing effect on the definition of health-plan contract, suggesting that a health-plan contract can be only what the definition expressly states that it is and not what one may additionally infer from the definition. BCBS offers that Congress would have used the term "includes" if it had intended that the definition be given an expansive interpretation. In fact, the legislative history, if anything, undermines BCBS's argument. When Congress added health-plan contracts to section 1729 in 1986 as an available source of reimbursement, the Senate Budget Committee issued a section-by-section analysis of the amendment, commenting on the definition of health-plan contract as follows: "The Committee intends

this definition to be construed broadly so as to achieve broad coverage under this section with respect to the types of health plans under which recoveries and collections may be sought." S. Rep. No. 146, 99th Cong., 2d Sess. 633 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 576. This statement does not evince congressional intent to limit the definition of health-plan contract to the words of the legislation and thereby exclude medigap policies from the definition

BCBS argues that, by excluding the Medicare program from the definition of health-plan contract, Congress intentionally excised the triggering mechanism of a medigap policy. This argument rests on the same logic BCBS tried to use to avoid the application of section 1729's non-discrimination provision to its medigap policies. As discussed earlier, a medigap policy is not by definition dependent on the payment of Medicare benefits. Clearly, medigap policies can be "triggered" without payment of a Medicare benefit, and Congress's decision to exclude Medicare [5] has no effect on the application of the term "health-plan contract" to medigap policies.

BCBS points to legislative history that compares the term "health-plan contract" in 38 U.S.C. § 1729(i) to an employer/employee group contract, which is a primary health insurance contract and not a supplemental contract. Because Congress decided to exclude employer/employee insurance plans from its definition of medigap policies, BCBS contends that although a health-plan contract can be an employer/employee group contract, a

[5] Although the legislative history does not speak to this decision, a safe assumption to be drawn from the exclusion of Medicare from the definition of health-plan contract is that Congress wanted to avoid the unnecessary transfer of federal funds from Medicare to the VA when the money is all coming out of the same coffer. BCBS's suggested interpretation requires us to read more than the desire for administrative efficacy into Congress's decision without supporting interpretative guidance such as committee reports or hearing transcripts.

medigap policy cannot. Therefore, a medigap policy also cannot be a health-plan contract. This conclusion is not logical for two reasons. First, a health-plan contract represents more varieties of reimbursement mechanisms than a medigap policy. A health-plan contract, on the one hand, can include any agreement to provide or pay for health care including hybrid sources such as "Living Needs" life insurance policies that permit the insured to make an early claim on a death benefit at the time of a catastrophic illness or dental or optical policies that are considered not primary payers but insurers in the event of a particularized health problem. A medigap policy, on the other hand, is statutorily limited to a certain category of coverage. Therefore, comparison of the characterizations of the two terms serves no authoritative purpose. Second, Congress demonstrated in both the definition of health-plan contract, 38 U.S.C. § 1729(i)(1)(B)(i)-(iv), and the definition of Medicare supplemental policy, 42 U.S.C. § 1395ss(g)(1), that it wanted to place limitations on the terms. In each provision, Congress clearly delineated the circumstances not included in the definitions, and did not exclude expressly one term from the definition of the other. Congress amended the definition of Medicare supplemental policy in 1990, after the passage of section 1729, and could have excluded health-plan contract at that time but did not. Given Congress's proclivity, in defining these terms, to enumerate excluded items, its decision to exclude employer/employee group contracts from the definition of Medicare supplemental policy does not suggest inferentially that Congress wanted to exclude medigap policies from the definition of health-plan contract.

Finally BCBS argues that Congress's two unsuccessful attempts to amend section 1729(i) to include medigap policies within the definition of health-plan contract evinces a legislative intent to exclude medigap policies from the meaning of that term. In 1990 Congress amended section 1095 of title 10, chapter 55, dealing

with the health care of the armed forces. Section 1095 permits the United States to collect from third-party payers, including insurance, medical service, and health plans, the reasonable cost of health care services incurred in the treatment of members of the armed forces. 10 U.S.C. § 1095(a)(1). The 1990 amendment details that "insurance, medical service, or health plan" includes an insurance plan described as Medicare supplemental insurance. *Id.* § 1095(h)(2).

On two occasions Congress has attempted to add similar language to section 1729, but the measures have not passed. S. 1271, 102d Cong., 1st Sess. § 2 (1991); S. 2455, 101st Cong., 2d Sess. § 5 (1990). BCBS claims that Congress's failure to pass the amendments indicates that Congress does not intend the definition of health-plan contract to include medigap policies. Because Congress's failure to pass the amendments also could signify its understanding that the definition of health-plan contract already includes medigap policies, we can infer little from congressional inaction alone. In this case, however, the legislative history suggests that Congress's intent in trying to pass the amendments was merely to clarify the definition of health-plan contract and not to broaden it. The following segments from debates on the measure best demonstrate the significance of Congress's efforts:

> While many insurers who offer these [medigap] plans reimburse VA, a number of insurers have taken the position that, because VA may not collect from Medicare, there is no liability on medigap policies.
>
> The specific reference to Medicare supplemental plans added by the bill is designed to allay any doubts as to whether medigap plans are required to reimburse VA under the program. For purposes of the recovery provisions in section [1729], medigap insurers must treat VA medical centers and personnel as if they were non-Federal hospitals and health

> care providers participating in the Medicare program. The medigap insurer must reimburse VA as if the claim has been previously submitted to and processed under Medicare. If the insurer is unable to determine its liability for the VA bill, it may instead make payment in an amount it can demonstrate to the satisfaction of the Secretary it would pay for the care and services if they had been furnished by a non-Federal Medicare provider.

137 Cong. Rec. S7471-01 (daily ed. June 11, 1991) (statement of Sen. Cranston); *see also* 136 Cong. Rec. S4568-01 (daily ed. Apr. 19, 1990) (statement of Sen. Cranston) (same language quoted in earlier debate). Congress appeared to want only to clarify section 1729 and not significantly alter it. Because Congress ultimately did neither, we reject BCBS's assertion that the proposed amendments to the definition of health-plan contract hold any significance.

With the failure of this final argument, BCBS falls short of establishing with any legal certainty that a medigap policy is not a health-plan contract. A health-plan contract need do only one of two things—provide health services or reimburse the expenses of such services. 38 U.S.C. § 1729(i)(1)(A). Without a doubt, medigap policies were designed to do just that by paying "benefits [which] are for services billed for by the hospital, physician, or provider." *See, e.g.*, Blue Cross and Blue Shield 65-Premium Contract, at 2. Therefore, we hold that BCBS's medigap policies are health-plan contracts governed by the non-discrimination and reimbursement mechanisms of section 1729.

IV

BCBS of Maryland is one of seventy-three similar BCBS organizations throughout the country. Twenty of the organizations currently reimburse the United States for services rendered at VA hospitals. BCBS's position dem-

onstrates calculated discrimination against veterans and callous indifference to its obligations to premium-paying enrollees in its medigap programs. The insurance business always has involved precise allocations of financial risks; the insured pays a given amount at set intervals to assuage the untimely outlay of unexpected funds and the insurer designs programs to limit its risk of unanticipated claims. In this case, however, BCBS is knowingly selling policies under which it never intends to pay. Medigap policies are health-plan contracts, and the non-discrimination provisions of section 1729 apply to health-plan contracts to prevent the exclusion of VA hospitals from their coverage. Therefore, we affirm the district court's decision to grant the government's motion for summary judgment, and thereby permit the United States to pursue the veteran patients' claims under medigap policies.

AFFIRMED

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

Civil No. Y-90-2653

UNITED STATES OF AMERICA

v.

BLUE CROSS AND BLUE SHIELD OF MARYLAND, INC.

Stuart A. Gerson, Esquire, Assistant Attorney General, Washington, D.C., Richard D. Bennett, Esquire, United States Attorney for the District of Maryland, Baltimore, Maryland, Roger D. Einerson, Esquire, Washington, D.C., and Colette J. Winston, Esquire, Washington, D.C., counsel for the plaintiff.

Philip V. Tamburello, Esquire, Owings Mills, Maryland, and Lawrence A. Richardson, Jr., Esquire, Owings Mills, Maryland, counsel for the defendant.

YOUNG, Joseph H., Senior United States District Judge.

DATE: May 14, 1992.

MEMORANDUM

Plaintiff brings this action pursuant to 38 U.S.C. § 1729 (the "non-discrimination" act) to recover the cost of care and services furnished to eleven veterans at a Veterans Administration Medical Center, Martinsburg, West

Virginia. The eleven veterans are "Medicare eligible" and covered by Medicare Supplemental Insurance Policies provided by Defendant Blue Cross and Blue Shield of Maryland.[1]

Section 1729 provides that the United States is entitled to recover benefits from a "third party payor" for services rendered to a veteran at a VA hospital to the extent that such benefits would be recoverable if the service provider were not an agency of the United States. 38 U.S.C. 1729(a)(1). However, benefits for services rendered at a VA hospital may not be recovered from Medicare or Medicaid.[2] Plaintiff suggests that Congress excluded Medicare and Medicaid from the definition of a health plan contract because there was no useful purpose in moving federal funds from one program to another. In the absence of clear congressional intent to the contrary, Plaintiff's suggested reason for the exclusion of Medicare and Medicaid is plausible.[3]

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[1] "Medicare eligible" means 65 years of age and older, or those who are under age 65 and eligible because of a disability.

A "Medicare Supplemental Policy" is defined as a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to medicare, which provides reimbursement for expenses incurred for services that are Medicare approved, but are not reimbursable because of deductibles, coinsurance amounts, or other limitations. 42 U.S.C. § 1395ss.

[2] The United States is entitled to recover for non-service connected disabilities incurred by a veteran who is covered by a "health plan contract." 38 U.S.C. § 1729(a)(2)(D)(ii). Medicare and Medicaid are specifically excluded from the definition of a health plan contract. 38 U.S.C. § 1729(i)(1)(B)(i).

The encating statutes for Medicare and Medicaid contain a similar limitation—"no payment may be made under this part to any Federal provider of services." 42 U.S.C. § 1395f (The exceptions listed in § 1395f are not relevant to this case.)

[3] Defendants have reviewed the construction and legislative history of Medicare, Medicaid and the the non-discrimination act. Essentially, Defendants conclude that (1) Blue Cross is not liable for *Medicare supplemental payments* pursuant to its Contracts with

Medicare Supplemental Insurance Contracts provide benefits to subscribers, eligible to receive Medicare, for certain expenses not paid by Medicare. Some of the expenses, such as deductibles and co-payments, are set amounts established by contract and statute. Other expenses are calculated as a percentage of "Medicare Approved Charges."

First Defense

Defendants contend that because VA Hospitals are not eligible to receive benefits from Medicare, plaintiff is not entitled to recover under the Medicare Supplemental Contracts. This contention is without merit. A Medicare Supplemental Contract is statutorily defined as a "health insurance policy" or "other health benefit plan." 42 U.S.C. 1395ss. Such contracts are entered into between private parties, but are subject to regulation by the Department of Health and Human Services. Section 1729 applies to a "health plan contract" which is broadly defined as an "insurance policy or contract," "membership or subscription contract, or similar arrangement." 38 U.S.C. 1729. Congress clearly intended Section 1729 to apply to Medicare Supplemental Contracts.[4] *United States v. State of N.J.; Violent Crimes Comp. Bd.*, 831 F.2d 458, 461-62 (3d Cir. 1987) (holding that Section

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subscriber-veterans because Federal Medicare law and regulation does not authorize *Medicare payments* for services rendered at VA hospitals; and (2) Blue Cross is not liable for the charges as determined by Plaintiff because those charges are not necessarily "Medicare Approved Charges" upon which liability under the Supplemental Contracts is based.

[4] Section 1095, 10 U.S.C. is analogus to the non-discrimination provision at issue in this case. That section prohibits discrimination by a third party payor for services rendered in military facilities. Section 1095 was enacted five years after Section 1729. Congress specifically included a Medicare Supplemental Insurance Contract in the definiton of an "insurance, medical service, or health plan" contract. 10 U.S.C. § 1095(h).

1729 requires that "a recovery claim by the United States be analyzed as if the veteran had received care in a hospital other than a VA hospital-in other words, as if the veteran has been treated by a provider that charged patients for care."). See also, *United States v. State of Maryland*, 914 F.2d 551, 552 (4th Cir. 1990).

Second Defense

In the alternative, Defendants argue that the Government must submit its claims to Medicare for a determination of "Medicare Approved Charges." Defendants' contractual liability under the Supplemental Contracts depends upon such a determination. The value of the services rendered to each of the eleven veterans was calculated by the Secretary of Veteran's Affairs in accordance with the appropriate rates established by the Office of Management and Budget.[5] 42 U.S.C. 1729 and 42 U.S.C. 2651. Defendants deny that such charges would be reasonable as determined by Medicare—42 U.S.C. 1395ff, 42 U.S.C. 1395x(v) and 42 U.S.C. 1395u—or even "medically necessary" as determined by Medicare. 42 U.S.C. 1395h and 42 CFR Part 421.

Charges determined by the Secretary of Veteran's Affairs are required by statute to be equal to or less than the amount that a third party payor would be obligated to pay if the services were not rendered by a facility of

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[5] Section 1729(a)(1) provides that the reasonable cost of services rendered by a VA hospital will be determined by the Secretary of Veteran's Affairs. This provision directly contradicts the remainder of the paragraph which provides that the United States is entitled to recover from a third party, only "to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States." The provision also alters the obligations of the parties to a Medicare Supplemental Contract under which the insurer's liability depends upon "Medicare Approved Charges."

the United States. 38 U.S.C. § 1729.[6] Since Medicare Approved Charges are statutorily defined, disputes regarding charges as determined by the Secretary of Veteran's Affairs should be relatively few. There is no indication in the record that Defendant has ever raised the issue of an over charge with the Secretary of Veteran's Affairs. Thus, summary judgment is appropriate and Defendant is directed to resolve the issue with the Department of Veteran's Affairs.

/s/ [Illegible]
Senior United States District Judge

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[6] Section 1729 provides "the reasonable cost of care or services sought to be recovered or collected from a third-party liable under a health-plan contract may not exceed the amount that such third party demonstrates to the satisfaction of the Secretary it would pay for the care or services if provided by facilities (other than facilities of departments or agencies of the United States) in the same geographic area." 38 U.S.C. 1729(c)(2)(B).

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 92-1781
CA-90-2653-Y

UNITED STATES OF AMERICA
Plaintiff-Appellee

v.

BLUE CROSS & BLUE SHIELD OF MARYLAND, INCORPORATED,
Defendant-Appellant

BLUE CROSS AND BLUE SHIELD ASSOCIATION,
Amicus Curiae

On Petition for Rehearing with
Suggestion for Rehearing In Banc

Filed April 16, 1993

Appellant's petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

/s/ Bert M. Montague
Clerk

APPENDIX D

STATUTORY PROVISIONS INVOLVED

§ 1095. Health care services incurred on behalf of covered beneficiaries: collection from third-party payers

(a)(1) In the case of a person who is a covered beneficiary, the United States shall have the right to collect from a third-party payer the reasonable costs of health care services incurred by the United States on behalf of such person through a facility of the uniformed services to the extent that the person would be eligible to receive reimbursement or indemnification from the third-party payer if the person were to incur such costs on the person's own behalf. If the insurance, medical service, or health plan of that payer includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount that the United States may collect from the third-party payer is the reasonable cost of the care provided less the appropriate deductible or copayment amount.

(2) A covered beneficiary may not be required to pay an additional amount to the United States for health care services by reason of this section.

(b) No provision of any insurance, medical service, or health plan contract or agreement having the effect of excluding from coverage or limiting payment of charges for certain care if that care is provided through a facility of the uniformed services shall operate to prevent collection by the United States under subsection (a).

(c) Under regulations prescribed under subsection (f), records of the facility of the uniformed services that provided health care services to a beneficiary of an insurance, medical service, or health plan of a third-party payer shall be made available for inspection and review

by representatives of the payer from which collection by the United States is sought.

(d) Notwithstanding subsections (a) and (b), collection may not be made under this section in the case of a plan administered under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.) [42 USCS §§ 1395 et seq. or 1396 et seq.].

(e)(1) The United States may institute and prosecute legal proceedings against a third-party payer to enforce a right of the United States under this section.

(2) The administering Secretary may compromise, settle, or waive a claim of the United States under this section.

(f) The Secretary of Defense, in consultation with the other administering Secretaries, shall prescribe regulations for the administration of this section. Such regulations shall provide for computation of the reasonable cost of health care services. Computation of such reasonable cost may be based on—

(1) per diem rates;

(2) all-inclusive per visit rates;

(3) diagnosis-related groups; or

(4) such other method as may be appropriate.

(g) Amounts collected under this section from a third-party payer for the costs of health care services provided at a facility of the uniformed services shall be credited to the appropriation supporting the maintenance and operation of the facility.

(h) In this section:

(1) The term "third-party payer" means an entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier.

(2) The term "insurance, medical service, or health plan" includes an insurance plan described as Medicare supplemental insurance.

(i)(1) In the case of a third-party payer that is an automobile liability insurance or no fault insurance carrier, the right of the United States to collect under this section shall extend to health care services provided to a person entitled to health care under section 1074(a) of this title.

(2) In cases in which a tort liability is created upon some third person, collection from a third-party payer that is an automobile liability insurance carrier shall be governed by the provisions of Public Law 87-693 (42 U.S.C. 2651 et seq.).

(Added Apr. 7, 1986, P. L. 99-272, Title II, § 2001 (a)(1), 100 Stat. 100; Nov. 29, 1989, P. L. 101-189, Div. A, Title VII, Part B, § 727(a), Title XVI, Part C, § 1622(e)(5), 103 Stat. 1480, 1605; Nov. 5, 1990, P. L. 101-510, Div. A, Title VII, Part B, § 713(a)-(d), 104 Stat. 1583; April 6, 1991, P. L. 102-25, Title VII, § 701 (j)(8), 105 Stat. 116; Dec. 5, 1991, P. L. 102-190, Div. A, Title VII, Part B, § 714, 105 Stat. 1403.)

38 U.S.C. 1729

§ 1729. Recovery by the United States of the cost of certain care and services

(a)(1) Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter [38 USCS §§ 1701 et seq.] for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services

from such third party if the care or services had not been furnished by a department or agency of the United States.

(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

(A) that is incurred incident to the veteran's employment and that is covered under a workers' compensation law or plan that provides for payment for the cost of health care and services provided to the veteran by reason of the disability;

(B) that is incurred as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance;

(C) that is incurred as the result of a crime of personal violence that occurred in a State, or a political subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime;

(D) that is incurred by a veteran—

(i) who does not have a service-connected disability; and

(ii) who is entitled to care (or payment of the expenses of care) under a health-plan contract; or

(E) for which care and services are furnished before October 1, 1993, under this chapter [38 USCS §§ 1701 et seq.] to a veteran who—

(i) has a service-connected disability; and

(ii) is entitled to care (or payment of the expenses of care) under a health-plan contract.

(3) In the case of a health-plan contract that contains a requirement for payment of a deductible or copayment by the veteran—

(A) the veteran's not having paid such deductible or copayment with respect to care or services furnished under this chapter shall not preclude recovery or collection under this section; and

(B) the amount that the United States may collect or recover under this section shall be reduced by the appropriate deductible or copayment amount, or both.

* * * *

(f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 1711(b) of this title.

* * * *

(i) For purposes of this section—

(1)(A) The term "health-plan contract" means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.

(B) Such term does not include—

(i) an insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j);

(ii) a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.);

(ii) a workers' compensation law or plan described in subparagraph (A) of subsection (a)(2) of this section; or

(iv) a program, plan, or policy under a law described in subparagraph (B) or (C) of such subsection.

(2) The term "payment" includes reimbursement and indemnification.

(3) The term "third party" means—

(A) a State or political subdivision of a State;

(B) an employer or an employer's insurance carrier;

(C) an automobile accident reparations insurance carrier; or

(D) a person obligated to provide, or to pay the expenses of, health services under a health-plan contract.

(Added Nov. 3, 1981, P. L. 97-72, Title I, § 106(a)(1), 95 Stat. 1050; Apr. 7, 1986, P. L. 99-272, Title XIX, Subtitle A, § 19013(a), 100 Stat. 382; May 20, 1988, P. L. 100-322, Title II, Part A, § 202, 102 Stat. 509; Nov. 5, 1990, P. L. 101-508, Title VIII, Subtitle B, § 8011(a)-(c), 104 Stat. 1388-344; May 7, 1991, P. L. 102-40, Title IV, § 402(d)(1), 105 Stat. 239; Aug. 6, 1991, P. L. 102-83, §§ 4(b)(1), (2)(E), 5(a), (c)(1), 105 Stat. 404-406.)

42 U.S.C. 1395ss

§ 1395ss. Voluntary certification of Medicare supplemental health insurance policies

(a) Submission of policy by insurer. (1) The Secretary shall establish a procedure whereby medicare supple-

mental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Subject to subsections (k)(3), (m), and (n), such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

* * * *

(b) Periodic review of State regulatory programs. (1) Any medicare supplemental policy issued in any State which the [the] Secretary determines has established under State law a regulatory program that—

(A) provides for the application and enforcement of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A));

(A) [Caution: applicable only in 15 States (as determined by the Secretary of Health and Human Services) and only during the 3-year period beginning with 1992] provides for the application of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A)), except as otherwise provided by subparagraph (H);

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) through (5) of subsection (c);

(C) provides that—

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary.

and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;

(D) provides for application and enforcement of the standards and requirements described in subparagraphs (A), (B), and (C) to all medicare supplemental policies (as defined in subsection (g)(1) issued in such State,

(E) provides the Secretary periodically (but at least annually), with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary.

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase, and

(H) [Caution: applicable only in 15 States (as determined by the Secretary of Health and Human Services) and only during the 3-year period beginning with 1992] in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t).

shall be deemed (subject to subsections (k)(3), (m), and (n), for so long as the Secretary finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c). The report required under subsection (F) shall include information on loss ratios of poli-

cies sold in the State, frequency and types of instances in which policies approved by the State fail to meet the standards of this paragraph, actions taken by the State to bring such policies into compliance, and information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners, may specify.

* * * *

(g) Definitions. (1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under section 1876 [42 USCS § 1395mm] or an agreement under section 1833 [42 USCS § 1395*l*]. For purposes of this section, the term "policy" includes a certificate issued under such policy.

(2) For purposes of this section:

(A) The term "NAIC Model Standards" means the "NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act", adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplement [supplemental] policies.

(B) The term "State with an approved regulatory program" means a State for which the Panel has made a determination under subsection (b)(1).

(C) The State in which a policy is issued means—

(i) in the case of an individual policy, the State in which the policyholder resides; and

(ii) in the case of a group policy, the State in which the holder of the master policy resides.

* * * *

42 U.S.C. 1395y

§ 1395y. Exclusions from coverage

(a) Items or services specifically excluded. Notwithstanding any other provision of this title [42 USCS §§ 1395 et seq.], no payment may be made under part A or part B [42 USCS §§ 1395c et seq., 1395j et seq.] for any expenses incurred for items or services—

* * * *

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined

in section 1861(aa)(1) [42 USCS § 1395x(aa)(1)], [,] in the case of Federally qualified health center services, as defined in section 1861(aa)(3) [42 USCS § 1395x(aa)(3)], and in such other cases as the Secretary may specify;